| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 555853 | A. BUILDING _____ B. WING _____ | 05/07/2009 |

| N OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| VETERANS HOME OF CALIFORNIA - BARSTOW | 100 EAST VETERANS PARKWAY BARSTOW, CA 92311 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
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| F 000 | INITIAL COMMENTS<br><br>Surveyor: 10761<br>The following reflects the findings of the California Department of Public Health during a Recertification survey.<br><br>Representing the California Department of Public Health:<br><br>Carolyn Johnson, HFEN<br>Naomi Russell, HFEN<br>Manny Dumangas, HFEN<br>Elna Ramos, HFEN<br>Lena Resurreccion, HFES<br><br>Census 60 beds SNF/NF (18/19) = 17<br><br>Census 60 beds DP ICF<br>Certified NF (19 only) = 58<br><br>The census for the total Certified beds: 75<br><br>Residence Sample size: 15 | F 000 | Preparation and execution of this plan of correction in no way constitutes an admission or agreement by the Veterans Home of California-Barstow of the truth of the facts alleged in this statement of deficiencies and plan of correction. This plan of correction is submitted to comply with State and Federal law. This plan of correction serves as our credible allegation of compliance. | |
| F 170<br>SS=D | 483.10(i)(1) MAIL<br><br>The resident has the right to privacy in written communications, including the right to send and promptly receive mail that is unopened.<br><br>This REQUIREMENT is not met as evidenced by:<br>Surveyor: 11624<br>Based on interview, observation, and a review of policy and procedure, the facility failed to ensure that the resident's mail is delivered as specified in the facility's admission policy for 18 of 18 residents that attended the resident group | F 170 | *F 170, 483.10(i)(1)*<br>*MAIL: It is the policy of the Veterans Home of California-Barstow for its' residents to have the right to privacy in written communication, including the right to send and promptly receive mail that is unopened.*<br><br>Corrective Action<br>On May 28, 2009 all Activity Coordinators and Rehabilitation Therapist were given in-service training on the required mail delivery procedures for the SNF-700 unit and the ICF- 300 units.<br>(F 170 cont. next page) | 5-28-09 |

ABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

6-4-09

ny deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that he guards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days llow the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 ys following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued ogram participation.

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| F 170 | Continued From page 1<br>meeting.<br><br>Findings:<br><br>During the group interview at 3 p.m.on 5/5/09, it was stated by the resident responsible for delivering the mail that when he was not in the facility, the mail was not delivered until he returned to the facility.<br><br>This resident who delivered the mail had been observed on 5/4/09, sorting the mail for the other residents and delivering the mail to each of the resident's room. He stated, that he was "given the mail for the facility and he hand delivered it to each resident or left it on their bed if they were not in their room."<br><br>A review of the facility's policy titled: Veterans Home of California-Barstow Resident Admission information was written for the DOMS (domiciliary) facility and did not include information for the intermediate care residents in certified beds, and/or the skilled nursing residents in certified beds. The policy indicates: "... US (United States) postal mails is delivered to "A" building six days a week. Mail is then sorted and distributed to each building and placed in each resident's private mail box..."<br><br>Only the individuals residing in the DOMS have private mail boxes.<br><br>No system was in place to deliver the mail per the facility policy. | F 170 | Procedure for identifying other residents potentially affected<br>As all residents are potentially affected, on May 8, 2009 a random sampling of residents were interviewed regarding mail delivery. No further deficiencies were noted.<br><br>Systemic Changes and Quality Assurance Monitoring<br>Activity Coordinators assigned to the SNF-700 unit and the ICF-300 unit will be assigned to deliver mail daily when the resident volunteer is absent. A monthly monitor will be used to audit this process. This monitor will be presented at the quarterly Quality Assurance Meeting for review and further corrective actions. The Standards Compliance Coordinator will monitor for compliance. | |
| F 241<br>SS=D | 483.15(a) DIGNITY<br><br>The facility must promote care for residents in a manner and in an environment that maintains or | F 241 | *F 241, 483.15(a)*<br>*DIGNITY: It is the policy of the Veterans Home of California-Barstow to promote care for residents in a manner*<br>(F 241 cont. next page) | |

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| F 241 | Continued From page 2<br>enhances each resident's dignity and respect in full recognition of his or her individuality.<br><br>This REQUIREMENT is not met as evidenced by:<br>Surveyor: 10761<br>Based on observation, interview, and a review of the Medication Administration Record (MAR), the facility failed to ensure that residents were served meals in a timely manner taking into consideration medical conditions and continuing generalized pain for 1 of 15 sampled residents. (Resident 2)<br><br>Findings:<br><br>On 5/5/09 at 11:45 a.m., sampled Resident 2 was observed seated at a dining room table, his lunch had not been served and he was splinting (holding) his right side at intervals. Resident 2 was interviewed and he said that he was in pain although he had received pain medication that morning. Resident 2 said, "I was almost asleep and they got me up to come here."<br><br>One dietary staff was taking meal request one-resident-at-a-time, walking back and forth from the dining table to the serving table; the process was very slow. Three nursing staff (one registered nurse and two certified nursing assistants) stood against the wall, but did not assist in the meal delivery process. Resident 2 had not received his lunch by 12 noon.<br><br>On 5/7/09, during a review of Resident 2's Medication Administration Record (MAR), it was noted that he has diagnoses that include Hospice care. The MAR indicates staff are to monitor for | F 241 | *and in an environment that maintains or enhances each resident's dignity and respect.*<br><br>Corrective Action<br>Please note, Resident #2 came into the Dining area at approximately 11:45 am and was offered beverages and an appetizer. Resident #2 declined the appetizer at first then changed his mind. In order to enhance currently compliant operations, on May 29, 2009, in-service training was provided to all food service employees on Proper Food Service Procedures to include correct sequence of meal service. Additionally, all nursing staff will receive in-service training regarding proper dietary procedures for meal service, signs/symptoms relating to administration of pain medication, and adverse affects that may present during meal times. This training will be completed on, or before June10, 2009.<br><br>Procedure for identifying other residents potentially affected<br>As all residents on the SNF-700 unit are potentially affected, the Food Service Manager and Administrative Nursing staff observed meals on May 6, 7, and 8, 2009 to evaluate compliance that meals were served timely. No further deficiencies were noted.<br>(F 241 cont. on next page) | 5-29-09<br><br>6-10-09 |

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| F 241 | Continued From page 3<br>pain every shift, "AM and PM." The entry dated "5/5/09 AM" (the day of the meal observation) indicates Resident 2's pain level was assessed as a seven (7 out of 10).<br><br>A Fentanyl 75 mcg/hr Transdermal Patch, replaced every 3-days, had been changed on the morning of 5/5/09. (Fentanyl is a Narcotic Analgesic used to treat generalized pain). | F 241 | Systemic Changes and Quality Assurance Monitoring<br>Compliance with this procedure will be monitored by the Senior Registered Nurse (SRN) or assigned designee monthly. Monitors will be presented at the quarterly Quality Assurance Meeting for review and further corrective action. The Standards Compliance Coordinator will monitor for compliance. | |
| F 309 SS=D | 483.25 QUALITY OF CARE<br><br>Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.<br><br>This REQUIREMENT is not met as evidenced by:<br>Surveyor: 10761<br>Based on observation, dietary staff interview, and medical record review, the facility failed to ensure that hydration was encouraged, when they failed to offer residents water and/or place the pitchers of water within each resident's reach rather than waiting for residents to make a request for 2 of 15 sampled residents. (Residents 8 and 9)<br><br>Findings:<br><br>On 5/4/09 at 5:15 p.m., during the dinner observation for sampled Residents 8 and 9, it was noted that the table settings did not include glasses of water and/or pitchers of water in dining room 800. | F 309 | Moreover, a weekly dining room audit well be conducted by the Food Service Manager and verified by Standards Compliance Coordinator. The monitors will be presented at the quarterly Quality Assurance Meeting for review and further corrective action.<br><br>*F 309, 483.25*<br>*QUALITY OF CARE: It is the policy of the Veterans Home of California-Barstow to provide the necessary care and services to attain or maintain the highest practical physical, mental, and psychosocial well being.*<br><br>Corrective Action<br>Please note, on May 28, 2009 the Food Service Supervisor ordered smaller, easier to handle, water pitchers that will be placed on each table in the SNF-700 unit dining area to encourage hydration. Dietary staff will also offer residents water at each meal, before and after the meals. The Certified Nursing Assistants (F 309 cont. next page) | |

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| F 309 | Continued From page 4<br>On 5/5/09 at 11:45 a.m., the residents residing on the 300 Pod, including sampled Residents 8 and 9, were observed as they ate lunch in the 800 dining room. It was observed that neither Resident 8 nor Resident 9 had water on their table, but pitchers of water were on a serving cart out of the residents reach.<br><br>The same day at 12 noon, an interview was conducted with an individual who identified herself as the Assistant Director of Dining. She said, "They (dining room staff) offer water at the request of the residents, and if an individual has a hydration issue, then we push fluids."<br><br>On 5/5/09 at 12:15 p.m., after the interview with the Assistant Director of Dining, it was observed that dining room staff were carrying a pitcher of water from table to table offering to fill the resident's water glasses. Four of the 12 residents in the dining room immediately lifted their empty water glasses, indicating that they would like to have water with their meal.<br><br>On 5/4/09 during a review of Resident 9's medical record, it was noted that he has risk factors for dehydration that include Guillian-Barre Syndrome, cognitive impairment, depression and weight loss. (Guillian-Barre Syndrome is a weakness that varies widely in severity in different patients, usually begins in the legs, frequently involves the arms and often one or both sides of the face, the muscles of respiration or deglutition).<br><br>On 5/5/09 during a review of Resident 8's medical record it was noted that he has risk factors for dehydration that include kidney disease and cogitative impairment. | F 309 | (CNAs) assisting with meal service will also offer water to each resident during meals. In order to enhance currently compliant operations, all nursing staff will be in-serviced on or before June 10, 2009, on this new procedure to include proper dietary procedures and serving water at mealtime for hydration.<br><br>On May 29, 2009 in-service training was provided to all food service employees on Proper Food Service Procedures to include beverage orders and providing the residents with water.<br><br><u>Procedure for identifying other residents potentially effected</u><br>As all residents on the SNF-700 unit are potentially affected, the Food Service Manager and Administrative Nursing staff observed meals on May 6, 7 and 8, 2009 to evaluate compliance that water and other liquids were offered to the residents. No further deficiencies were noted.<br><br><u>Systemic Changes and Quality Assurance Monitoring</u><br>A monthly audit will be conducted by the Senior Registered Nurse (SRN) or designee, to evaluate the compliance with this procedure. Monitors will be presented to the quarterly Quality Assurance Meeting for review and further corrective action. The Standards Compliance Coordinator will monitor for compliance. | 6-10-09<br><br>5-29-09 |
| F 362 | 483.35(b) DIETARY SERVICES - SUFFICIENT | F 362 | [ F 362 starts next page] | |

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| F 362 SS=D | Continued From page 5<br>STAFF<br><br>The facility must employ sufficient support personnel competent to carry out the functions of the dietary service.<br><br>This REQUIREMENT is not met as evidenced by:<br>Surveyor: 13033<br>Based on observation and dietary staff interview, the facility failed to ensure that nursing and dietary staff were working together to provide meals in a timely manner, and failed to assure hydration was encouraged for 3 of 15 sampled residents and 8 unsampled residents. (Residents 2, 8, and 9)<br><br>Findings:<br><br>1. On 5/5/09 at 11 a.m. in the 800 Pod dining area, 12 residents waited 45 minutes for lunch trays to be served. The steam cart, which contained food items, arrived at 11:30 a.m. as three nursing staff (one registered nurse and two certified nursing assistants) were observed standing along the wall of the dining room waiting to assist the residents who required total assistance during meals.<br><br>During the lunch observation, one dietary staff approached each table to take orders for the appetizer, and then the same dietary staff brought the orders to the dietary server who was positioned at the steam table. After the appetizer order was filled at the steam table, the dietary staff brought the items back to the resident's table. This process was repeated for all six | F 362 | The Food Service Manager or designee will also monitor for compliance through a weekly dining room audit. Monitors will be presented to the quarterly Quality Assurance Meeting for review and further corrective action. The Standards Compliance Coordinator will monitor for compliance.<br><br>*F 362, 483.35(b)*<br>*DIETARY SERVICES-SUFFICIENT: It is the policy of the Veterans Home of California-Barstow to provide sufficient support staff personnel to carry out the functions of dietary service.*<br><br>Corrective Action<br>Please note, during the meal observed on May 5, 2009 the facility was observing Cinco de Mayo. In celebrating the event, the menu was quite extensive and the food offered was more than normal. Due to the fact that this type of service is more of a restaurant style, the time needed for service of residents varies depending on the menu selections. In-service training to include proper dietary procedures to include socializing and interacting with residents during mealtime and will be provided on or before June 10, 2009.<br><br>On May 29, 2009 in-service training was provided to all food service employees on Proper Food Service Procedures to include, taking residents<br>(F-362 cont. next page) | 6-10-09<br><br>5-29-09 |

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| F 362 | Continued From page 6<br>tables.<br><br>On the same date and time, the Dietary Supervisor (DS) was asked why the dietary staff is the only person serving the tray. The Dietary Supervisor stated, "We wanted to maintain the cleanliness by having one dietary staff obtain meal orders and serve the trays. The nursing staff will feed the residents, and put away used trays and containers after the meal." The DS was then asked, who served the meal tray for residents who are in their bedrooms, she responded saying, "The nursing staff serve the meal tray for residents who are in their bedroom."<br><br>Surveyor: 10761<br>2. On 5/5/09 at 11:45 a.m., residents residing on the 300 Pod, including sampled Residents 8 and 9, were observed as they ate lunch in the 800 dining room. Neither Resident 8 nor Resident 9 had water on their table, but pitchers of water were on a nearby serving cart out of their reach. Three staff were standing with their backs against the wall making no effort to offer residents water from the serving cart.<br><br>The same day at 12 noon, an interview was conducted with an individual who identified herself as the Assistant Director of Dining. She said, "They (dining room staff) offer water at the request of the residents, and if an individual has a hydration issue, then we push fluids."<br><br>On 5/5/09 at 12:15 p.m., after the interview with the Assistant Director of Dining, it was observed that dining room staff were carrying the pitcher of water from table to table offering to fill the resident's water glasses. Four of the 12 residents | F 362 | food order and filling them in accordance with dietary requirements. In order to prevent any issues of cross contamination and to provide diet accuracy, a trained dietary employee will take the resident's food order and fill it in accordance with dietary requirements.<br><br><u>Procedure for identifying other residents potentially effected</u><br>As all residents on the SNF-700 unit are potentially affected, on May 6, 7, and 8, 2009 the Food Service Manager and Administrative Nursing staff observed meals to evaluate compliance that meals were served timely and water was offered to residents. No further deficiencies were noted.<br><br><u>Systemic Changes and Quality Assurance Monitoring</u><br>A monthly audit will be conducted by the Senior Registered Nurse (SRN) or designee to evaluate the compliance with this procedure. Monitors will be presented to the quarterly Quality Assurance committee for review and evaluation for compliance with regulatory standards. The Standards Compliance Coordinator will monitor for compliance.<br><br>A weekly dining room audit will be conducted by the Food Service Manager or designee for compliance of proper<br>(F 362 cont. next page) | |

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| F 362 | Continued From page 7<br>in the dining room immediately lifted their water glasses indicating a desire for water with their meal. | F 362 | food service procedures. Monitors will be presented to the quarterly Quality Assurance Meeting for review and further corrective action. The Standards Compliance Coordinator will monitor for compliance. | |
| F 364 SS=D | 483.35(d)(1)-(2) FOOD<br><br>Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature.<br><br>This REQUIREMENT is not met as evidenced by:<br>Surveyor: 11624<br>Based on resident interview, dietary staff interview, and a review of the facility's policy and procedures, the facility failed to ensure that the potatoes were not undercooked and the hot food was not cold when the residents sat down to eat for the 18 residents that attended the Group Meeting.<br><br>Findings:<br><br>During the group interview at 3 p.m. on 5/5/09, it was stated by several of the residents that the kitchen was not using the steam table properly. By the time they went through the line and sat down to eat the food was already cold. The residents also stated that the cut up potatoes were undercooked. The baked potatoes were still hard, and both were difficult to eat.<br><br>The residents stated that they had brought to the attention of the dietary staff on many occasions that both potatoes were difficult to eat and nothing had been done. | F 364 | *F364 483.35(d)(1)-(2)*<br>*FOOD: It is the policy of the Veterans Home of California-Barstow to provide food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature.*<br><br>Corrective Action<br>On May 14, 2009 in-service training was provided to all food service employees on cooking procedures. This training discussed the importance of proper cooking technique and testing of food items (including potatoes) prior to service of menu items. Cafeteria Supervisors are to sample potato items prior to each meal they serve. Please note, the steam table is used properly and food temperatures are recorded twice per meal. Plates are preheated in plate lowerators and plate covers are offered at all three meals per day.<br><br>Procedure for identifying other residents potentially effected<br>On May 5, 2009 the Food Service Manager inspected all equipment including the steam table, lowerators<br>(F 364 cont. next page) | 5-14-09 |

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| F 364 | Continued From page 8<br>Interview was conducted with dietary staff on 5/5/09 at 3:45 p.m. The staff stated that they would try and make the potatoes to the resident liking. They also stated that the steam table was being used properly, but they had no heat lamps to keep the food warm as the residents went through the line. | F 364 | and plate covers for proper operation and no further deficiencies were noted.<br><br>Systemic Changes and Quality Assurance Monitoring<br>Temperature monitor sheets are used to audit food temperatures twice per meal. Dining Room Supervisor or designee will use a check sheet to monitor potato consistency as they appear on the menu. These monitors will be presented at the quarterly Quality Assurance Meeting for review and further corrective action. The Standards Compliance Coordinator will monitor for compliance. | |
| F 371 SS=D | 483.35(i) SANITARY CONDITIONS<br><br>The facility must -<br>(1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and<br>(2) Store, prepare, distribute and serve food under sanitary conditions<br><br>This REQUIREMENT is not met as evidenced by:<br>Surveyor: 22975<br>Based on observation, dietary staff interview, and a review of the facility's policy and procedure, the facility failed to ensure that open food products are discarded after their expiration date.<br><br>Findings:<br><br>During an observation on 5/4/09 at 2:15 p.m. in the dry storage room of the main kitchen, a brown powdered substance inside an airtight plastic container was found on the shelf. The enclosed plastic container was labeled "Cocoa Powder" has an opened date of 10/28/08 and an expiration date of 4/28/09.<br><br>During an interview with the Director of Dining | F 371 | *F 371 483.35(i)*<br>*SANITARY CONDITIONS:*<br>*It is the policy of the Veterans Home of California-Barstow to store, prepare and distribute food items under sanitary conditions.*<br><br>Corrective Action<br>On May 4, 2009 the expired cocoa powder was discarded.<br><br>Procedure for identifying residents potentially affected<br>This deficiency is applicable to all residents. Therefore, on May 4, 2009 after the observation of the expired cocoa powder, the Food Service Manager made a complete inventory inspection of all stored food to check for any further expired items. No further deficiencies were noted.<br>(F 371 cont. on next page) | |

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| VETERANS HOME OF CALIFORNIA - BARSTOW | 100 EAST VETERANS PARKWAY BARSTOW, CA 92311 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
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| F 371 | Continued From page 9<br>Services (DDS), on 5/4/09 at 2:17 p.m., she stated that they only keep this type of food items for six months. She further stated, "It should have been thrown away."<br><br>The review of the facility policy and procedure titled "Storage Times And Temperature" dated 12/05 was conducted on 5/5/09 at 10 a.m. The review indicated, "POLICIES - Most products contain an expiration date. The words "sell-by" or "use-by" should precede the date." The review also indicated, "The "use-by" date is the last date that a food can be consumed..." It further indicated under Suggested Storage Times for Dry Ingredients or Products, "Dry ingredients or products, once opened, must be stored in airtight containers where ingredient name and expiration date clearly labeled." | F 371 | Systemic Changes and Quality Assurance Monitoring<br>On May 14, 2009 in-service training was provided to all food service employees on food storage, expiration dates and discarding of expired food items. Food Service Manager/or designee will monitor and document that dry food items are properly stored and expiration dates are current. Monitors will be presented to the quarterly Quality Assurance Meeting for review and further corrective action. The Standards Compliance Coordinator will monitor for compliance. | 5-14-09 |
| F 465 SS=D | 483.70(h) OTHER ENVIRONMENTAL CONDITIONS<br><br>The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.<br><br>This REQUIREMENT is not met as evidenced by:<br>Surveyor: 22975<br>Based on observation, interview, and record review, the facility failed to ensure that the two ice machines located in the main kitchen to provide ice for the residents are clean and free from lime deposits.<br><br>Findings:<br><br>During an observation on 5/4/09 at 3:10 p.m. in the main kitchen, two ice machines (1 and 2) | F 465 | *465, 483.70(h)*<br>*OTHER ENVIRONMENTAL CONDITIONS: It is the policy of the Veterans Home of California-Barstow to maintain equipment in a safe and clean condition including ice machines.*<br><br>Corrective Action<br>On May 4, 2009 upon discovery of residue in the ice machine by Health Facility Evaluator Nurse, the ice machine was cleaned per manufacturers guidelines to comply with regulatory standards. Also on May 14, 2009 in-service training was provided to all food service employees on the revised policy for cleaning of the ice machines.<br>(F 465 cont. on next page) | 5-14-09 |

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| | 555853 | A. BUILDING _____ B. WING _____ | 05/07/2009 |

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| F 465 | Continued From page 10<br>were found to have white residue on the following locations:<br><br>1. Ice machine 1, white residue on the aluminum chute cover inside the storage bin<br>2. Ice machine 2, white residue on the blue plastic chute cover inside the storage bin<br><br>During an interview with the Director of Dining Services (DDS), on 5/4/09 at 3:15 p.m., she stated, "The white residue found inside the ice machine storage bins was lime deposits." She also stated that a contractor comes in on a monthly basis to provide preventive maintenance for the ice machines. The DDS further stated, "The janitor conducts a weekly cleaning of the ice machine." However, when asked to provide the cleaning log for the ice machines, no documents were produced.<br><br>The Janitor Daily Cleaning Log for the period of 4/06/09 through 5/3/09 was reviewed on 5/4/09 at 3:20 p.m. It indicated that the janitor signed the cleaning log only twice out of seven days. There were no other indicators that the ice machine was cleaned during that period of time.<br><br>The facility policy and procedure titled "Ice Handling" dated 5/95, indicated under POLICIES, "Ice made by ice machines on the premises must be made with water from a source approved by the state/local health department. Ice only is permitted to be kept in the ice storage bin." The policy and procedure also indicated under PROCEDURES, "Inside of ice storage bins are cleaned on a biweekly (handwritten) basis." | F 465 | Procedure for identifying other residents potentially affected<br>This deficiency is applicable to all residents. Therefore, on May 4, 2009 all of the ice machines in the kitchen were inspected and cleaned per manufacturers guidelines. No further deficiencies were noted.<br><br>Systemic Changes and Quality Assurance Monitoring<br>Effective May 14, 2009, the policy for cleaning the ice machine was revised to include cleaning to be done weekly. Food Service Manager/or designee will document that the cleaning was performed. Monitors will be presented to the quarterly Quality Assurance Meeting for review and further corrective action. The Standards Compliance Coordinator will monitor for compliance. | |
| F 493<br>SS=D | 483.75(d)(1)-(2) GOVERNING BODY<br><br>The facility must have a governing body, or | F 493 | [F 493 starts next page] | |

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| F 493 | Continued From page 11<br>designated persons functioning as a governing body, that is legally responsible for establishing and implementing policies regarding the management and operation of the facility; and the governing body appoints the administrator who is licensed by the State where licensing is required; and responsible for the management of the facility<br><br>This REQUIREMENT is not met as evidenced by:<br>Surveyor: 13033<br>Based on observations during medication pass and mail distribution; and review of the facility's policies and procedures, the facility failed to ensure that the policies for obtaining fingerstick glucose level, resident admission information, and discharge plan of care documentation were followed.<br><br>Findings:<br><br>1. On 5/5/09 at 4:30 p.m., during medication pass observation, a licensed staff was observed obtaining a blood sample for testing the blood glucose level for an unsampled resident. The licensed staff was observed to wipe the puncture site with alcohol wipes and punctured the finger tip right after. It was further observed that the first drop was placed on the test strip.<br><br>On 5/6/09 at 9:30 a.m. review of the facility policy on "Obtaining a Fingerstick Glucose Level" indicated under procedure 6. "... Discard the first drop of blood if alcohol is used to clean the fingertips because alcohol may alter the results."<br>Surveyor: 11624<br>2. On 5/6/09 at 9 am during a review of Resident | F 493 | *F 493, 483.75(d)(1)-(2)*<br>*GOVERNING BODY:*<br>*It is the policy of the Veterans Home of California-Barstow to provide a governing body that is responsible for establishing and implementing policies regarding the management and operation of the facility.*<br><br>Corrective Action<br>All Licensed Nursing staff will follow the facility's Policy and Procedure when obtaining Blood Glucose Levels for Blood Glucose Testing by utilizing the criteria identified in the Policy Steps for Correct Procedure.<br><br>All Licensed Nursing staff will be in-serviced by the Nurse Instructor on the facility policy for *Obtaining Fingerstick Blood Glucose Levels* for testing when using alcohol for cleansing. In-service training will be completed on or before June 10, 2009. This training will include the correct procedure to be followed when obtaining a blood sample for glucose testing. This policy will be incorporated into the New Employee, Licensed Nurse orientation, of which employees will demonstrate skill proficiency.<br><br>Procedure for identifying resident potentially affected<br>This deficiency is applicable to all residents who are diabetic. Please note,<br>(F 493 cont. on next page) | 6-10-09 |

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| F 493 | Continued From page 12<br>15's closed record it was found that the transfer and discharge requirements had not been meet. No 30 day advanced notice of transfer was found within the record to show that the resident was notified. No orientation for transfer or discharge.<br><br>A review of Resident 15's MDS (Minimum Data Set) Discharge Tracking Form dated 2/26/09 stated under "Section R. Assessment/Discharge Information 3. Discharge Status 1. Private home/apartment with no home health services."<br><br>On 5/6/09 a review of facility policy titled Discharge Plan of Care-Documentation which stated: "Policy Statement: It is the policy of this facility to ensure that each resident has a planned program of care which meets his or her needs. Because this need may extend past the resident's in-house stay, a discharge plan of care will be initiated as soon as discharge to home, a nursing facility or residential care facility is anticipated. At the time of discharge, the resident and/or care giver will also be given detailed information about the resident's status, including instructions for continuing care."<br><br>An interview was held with facility staff on 5/6/09 at 1:45 pm. The staff stated that "We do not do these papers because they are going to the Dorms so we just don't do it."<br><br>3. On 5/5/09 at 3;45 p.m. a review of the facility's policy titled Veterans Home of California-Barstow Resident Admission information was observed to be written for the residents residing in the DOMS (Domiciliary) facility and did not include information for the ICF(Intermediate Care Facility) and SNF(Skilled Nursing Facility) residents residing on these units. The mail information | F 493 | on May 26, 2009 a random sampling of licensed nurses were observed by the Quality Assurance nurse in monitoring of proper procedures for fingerstick and glucose monitoring. No further deficiencies were noted.<br><br>Systemic Changes and Quality Assurance Monitoring<br>An audit will be done by the Infection Control / Quality Assurance/ Nurse or designee monthly, of a random sampling of Licensed Nurses. This monitor will be used to audit staff for compliance with utilizing correct procedure to obtain Fingerstick Blood Glucose Levels for testing. This monitor will be completed monthly for 3 months. Monitors will be presented to the quarterly Quality Assurance Meeting for review and further corrective action. The Standards Compliance Coordinator will monitor for compliance.<br><br>*Discharge Criteria Component of F 493*<br><br>Corrective Action<br>Upon notification of a resident's change in level of care or discharge, a Residential Team Conference (RTC) will be conducted to prepare a discharge plan of care. This will include the resident and/or family. The documentation will include the<br>(F 493 cont. next page) | 6-10-09 |

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| F 493 | Continued From page 13<br>stated "US (United States) postal mails is delivered to "A" building six days a week. Mail is than sorted and distributed to each building and placed in each resident's private mail box."<br><br>On 5/5/09 at 4:15 p.m. an interview was held with facility staff who reviewed the Resident Admission Information sheet and agreed that it had been written for the Doms as the SNIF and ICF did not have private mail boxes and their mail was delivered to them in their rooms. | F 493 | resident's status and instructions for continuing care. All Licensed Nursing staff will be in-serviced by the Nurse Instructor on the facility policy for Discharge Plan of Care-Documentation. In-service training will be completed by June 10, 2009.<br><br><u>Procedure for identifying residents potentially affected</u><br>This deficiency is applicable to all residents. Please note, on May 18, 2009 resident # 1 was transferred to the Doms. An audit was completed for the discharge process that is stated per facility policy. Items that were not included in the documentation were identified and corrected. No further deficiencies were noted.<br><br><u>Systemic Changes and Quality Assurance Monitoring</u><br>The Supervising Registered Nurse (SRN), upon a resident discharge will use a monitoring tool to identify the correct application of the discharge process. Monitors will be presented to the quarterly Quality Assurance Meeting for review and further corrective action. The Standards Compliance Coordinator will monitor for compliance. | 6-10-09 |